

February 12, 2007

U.S. Nuclear Regulatory Commission Washington, DC 20555

ATTENTION:

Document Control Desk

SUBJECT:

Calvert Cliffs Nuclear Power Plant

Unit No. 1; Docket No. 50-317; License No. DPR 53

Licensee Event Report 2006-004

Reactor Trip Due to Loose Wire During Maintenance on Turbine Control System

The attached report is being sent to you as required by 10 CFR 50.73. Should you have questions regarding this report, please contact Mr. Jay S. Gaines at (410) 495-4922.

Very truly yours,

Joseph E. Pollock Plant General Manager

JEP/SMR/bjd

Attachment:

As stated

cc:

D. V. Pickett, NRC

S. J. Collins, NRC

Resident Inspector, NRC

R. I. McLean, DNR

NRC FO	RM 366			U.S.	NUCLE	AR RE	GULATO	RY COMM	ISSION	APP	ROVE	D BY OMB	: NO. 3150-0	104	Ē	XPIRES:	06/30/2007
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S. M. Reichard, Engineering Analyst							410-495-3648					u 000e)					
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14. SUPPLEMENTAL REPORT EXPECTED 15. EXPECTED SUBMISSION SUBMISSION DATE 16. EXPECTED SUBMISSION DATE							YEAR										
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)																	
On December 12, 2006 at 0907 a.m., Unit 1 was manually tripped due to a pressure transient on																	
the primary system during performance of a turbine control system maintenance activity.																	
Subsequent trouble-shooting identified a wire was broken at the wire-to-connector interface in the electrical cabinet to Turbine Control Valve 3. The broken wire resulted in inaccurate																	
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	service. Unit 1 was returned to service December 16, 2006.																

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

I. DESCRIPTION OF EVENT

On December 12, 2006, maintenance was being performed on Unit 1 to replace Variable Servo Valve Operator (VSVO) cards on the new Mark VI turbine control system. In order to perform the maintenance on-line, one logic branch was de-energized at a time. When the first logic branch was de-energized, Turbine Control Valve 3 unexpectedly began to shut. Subsequent investigation determined that the turbine control valve shut due to a malfunctioning control valve position indication circuit. Control Room Operators manually tripped the reactor when they observed increasing Reactor Coolant System pressure.

Prior to the event, Unit 1 was operating in Mode 1 at 100 percent. The Reactor Coolant System was at normal operating pressure and temperature. There were no systems, structures, or components inoperable that contributed to the event.

All plant systems responded as designed during this event. Decay heat was removed via normal methods through the turbine bypass valves to the condenser, all control rods fully inserted as expected, the steam generators remained on normal feed throughout the event, and no power-operated relief valves or pressurizer safety valves lifted during the transient. Therefore the Unit 1 reactor trip is considered an uncomplicated trip.

The reactor was restarted on December 14, 2006 and paralleled to the grid on December 16, 2006.

II. CAUSE OF EVENT

The Mark VI turbine control system was installed during the Unit 1 Refueling Outage in 2006. The Mark VI turbine control system allows for on-line maintenance based on the redundancy of the circuitry.

Following troubleshooting of the Mark VI turbine control system for an incorrect valve stroke indication, Engineering personnel determined that certain VSVO cards were not updating correctly. The vendor (General Electric) was contacted and determined that the VSVO cards in question should be replaced. Discussion with the vendor and review of operating experience determined that the replacement could be safety performed while the unit remained at full power. Replacement cards were obtained and maintenance was scheduled for December 12, 2006.

An unexpected reactor coolant pressure increase occurred when one of the VSVO cards was deenergized during replacement. Turbine Control Valve 3 also changed position unexpectedly as a result of this condition. Operations manually tripped the reactor per procedure due to increasing reactor coolant pressure. All valves on the Unit 1 main turbine shut as expected and the trip had no unexpected results.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

A review of the trip and activities associated with the main turbine maintenance determined that the affected turbine control valve unexpectedly stroked shut when the selected VSVO card was deenergized because a broken wire on another VSVO card caused an erroneous position indication for the affected turbine control valve. Under these operating conditions, the turbine control valve should have remained 56 percent open. However, the erroneous position indication caused the control system to assume the valve was 93 percent open. The Mark VI turbine control system attempted to correct the indicated valve position by closing the valve further. The closure of the affected turbine control valve resulted in a rise in reactor coolant pressure since less energy was removed from the Reactor Coolant System.

An inspection was performed on the valve interface box for the affected turbine control valve and a broken wire was found on the Linear Variable Differential Transformer field cable. The wire was re-lugged and testing was performed to verify that the system was operating properly. Maintenance was completed on the system with replacement of the VSVO cards prior to restart of the Unit.

An apparent cause evaluation (IRE-018-885) determined that the cause of the trip was the broken wire. The wire was repaired and additional inspections were performed to verify there were no other broken wires.

III. ANALYSIS OF EVENT

The planned maintenance activity on December 12, 2006 involved de-energizing one of the three redundant logic branches of the MARK VI turbine control system. The control system self-diagnostics did not detect the broken wire on the Linear Variable Differential Transformer field cable from the interface box. The turbine control system began shutting the affected turbine control valve due to the combination of the de-energized logic branch plus the broken wire. Control Room Operators manually tripped the reactor when Reactor Coolant System pressure increased.

This event resulted in manual actuation of the Reactor Protective System and is therefore reportable pursuant to 10 CFR 50.73(a)(2)(iv)(A). An immediate Event Notification Report was made to the Nuclear Regulatory Commission (NRC Event Number 43046). Condition Report IRE-018-885 was initiated to capture this event.

There were no actual nuclear safety consequences incurred from this event. An estimated conditional core damage probability of 3E-06 and an estimated conditional large early release probability of 1E-07 were calculated for this event.

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^{17.} NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

IV. CORRECTIVE ACTIONS

- A. The wire was repaired and additional inspections were performed to verify there were no other broken wires. Preventative maintenance will be performed during refueling outages to check for wire integrity.
- B. A software upgrade will be installed during the 2008 Refueling Outage to allow the observation of Linear Variable Differential Transformer field input values and failures.

V. ADDITIONAL INFORMATION

A. Component Identification

Component	IEEE 803 EIIS Function	IEEE 805 System ID		
Main Turbine Control Valve 3	SCV	TA		

B. Previous Occurrences

A review of Calvert Cliffs' events over the past several years was performed. No previous occurrences were identified involving a reactor trip due to a broken wire in the main turbine control system.